STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 15,499
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Social Welfare denying her request to be exempted from transferring to a managed care component of the Medicaid program.

FINDINGS OF FACT

1. The petitioner is a woman who is a recipient of disability benefits and Medicaid. This past spring she was notified that she was required under the Department's regulations to be enrolled in a managed care plan. She requested an exemption from this requirement because the physician who is currently treating her is not and will not become a member of the managed care network. She does not believe that there are physicians in the plan who are capable of providing equally effective treatment to her.

2. The Department denied her request on May 11, 1998, saying that she needed to enroll in the managed care plan, choose a primary care physician and discuss a referral to a specialist with him or her.

3. The petitioner appealed that decision. Prior to her hearing, a conference was held at which she raised as a reason for an exemption her right under health care

financing regulations to receive a referral outside of a managed health care plan if no one within the plan had appropriate training and experience to meet her health care plan. At that time she was given a copy of the regulations listing situations in which exemptions for managed care are given and was allowed a month to review them and an opportunity to provide documentation from her health care providers if she chose.

4. The petitioner provided a letter from her physician which is attached hereto and incorporated herein by reference as Exhibit No. One. The petitioner further testified that she should not be placed in managed care because it is her belief no physicians in that system can adequately treat her. She recounted a long medical history of misdiagnosis and mistreatment of her medical condition and her inability to function prior to undertaking treatment with her current physician. She also described her current physician as the only one who did not cause her further harm and whose treatment had improved her ability to stand, walk and sit.

5. The petitioner agreed at hearing in response to specific questions that she did not meet any of the criteria listed in the regulations at M103 for persons who are excepted from managed care participation.

6. The Department agreed that under "Rule 10" of the Department of Banking and Insurance regulations, the

petitioner could get a referral to a person outside of the managed care network if there is no one in the network with appropriate training and experience who can meet the petitioner's health care plan. That question has not yet been reached by the Department because no ruling has been made yet by the Board that she must be in the managed care program.

ORDER

The decision of the Department requiring the petitioner to participate in the managed care program is affirmed.

REASONS

The managed health care program employed by Medicaid requires the Department to make a monthly payment to the plan for each person enrolled in the program, as opposed to paying individually for each health care service.

Persons found eligible for Medicaid benefits are required to enroll in one of two managed health care plans unless they are excluded by one of the provisions in regulation M103. M103.2. Those exceptions are as follows:

M103 Benefit Delivery Systems

Covered services for eligible recipients are provided through fee-for-service and managed health care delivery systems. With the exception of the following groups, all Medicaid recipients are required to enroll in managed health care plans, subject to plan availability and capacity. Recipients who are not eligible for managed health care plan enrollment are:

a) recipients who also have Medicare (Parts A and/or B);

b) home and community-based waiver recipients;

c) recipients living in long-term care facilities, including ICF/MRs;

d) recipients who are receiving hospice care when they are found eligible for Medicaid;

e) children under age 21 enrolled in the high-tech home care program;

f) recipients who have private insurance that includes both hospital and physician's services;

g) recipients residing in a geographic area where only one managed health care plan operates, unless they choose to be enrolled in that plan; NOTE: The standards the department uses to determine the geographic area that a managed health care plan serves are defined in the Welfare Procedures Manual at P-2443; these standards are in accordance with federal standards for access to care and the Vermont Health Resource Management Plan.

h) recipients who meet a spend-down who are not enrolled in a VHAP managed health care plan.

Exceptions from required enrollment may be made for individuals who would otherwise be enrolled in managed care for three months or less based on known changes, such as becoming Medicare-eligible.

For recipients required to enroll in managed health care plans, no payment will be made for services obtained outside the plan except for covered services designated wrap-around benefits. (See M103.22)[1]

The petitioner agrees that she does not meet any of the above exceptions in paragraphs a through h of the above regulation. Her request for an exemption is based solely on her belief that she will find no one who can treat her

[1] M103.22 provides that "[m]edicaid recipients enrolled in managed health care plans are eligible to receive additional services as defined in the State Plan and by regulation that are not included in the managed health care plan package..."

adequately in the managed care programs. If that contention proves to be true, it would form a basis for her to request services outside of the managed health care package. However, it is not a basis for exempting her from enrolling at the outset. It must be concluded, therefore, that the Department's decision that she is a required enrollee of managed care is correct under the above regulations.

It was explained to the petitioner at the hearing that she can request payment of a physician outside of the health care plan if no physician participating in the plan has appropriate training or experience to carry out her health care plan. That is a request she must take up with the administrators of the managed health care plan she chooses. The documentation she presented from her physician at this hearing should be provided to those persons.[2] If she can obtain no satisfactory result from such a request, she can appeal that matter to the Board.

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[2] It must be noted that while her physician did confirm the petitioner's need for specialized care and his qualifications to provide it, he did not go so far as to say that there are no providers in the managed health care plan who are similarly qualified. That is a hurdle which the petitioner may have to clear in providing future documentation of her request.